TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Shahrfar Ilami, DC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2662-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited incorrectly…Rule 134.204, Subsection (J), Subsection (4), Subparagraph (C), (ii), (II). This rule states if a full physical evaluation, with range of motion is performed, **reimbursement for the first musculoskeletal body area is $300.00 and each additional musculoskeletal body area is $150.00**…."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **12/16/2014**.

The requestor, as Designated Doctor, performed MMI and IR exams of the claimant on the date above and then billed Texas Mutual one unit of code 99456-W5-WP. The requestor placed the claimant in DRE category II.

Further, the requestor documented a full physical exam but not full range of motion. The requestor only performed range of motion to the lumbar spine."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2014	Designated Doctor Examination (MMI/IR)	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) **If full physical evaluation, with range of motion, is performed**: (-a-) $300 for the first musculoskeletal body area" [emphasis added]. The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the lumbar spine. Therefore, the correct MAR for this examination is $300.00.

2. The total allowable for the disputed services is $650.00. The insurance carrier paid $500.00. Therefore, an additional reimbursement in the amount of $150.00 is recommended.

Conclusion

This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 28, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

For disputes filed after June 1, 2012 use this one (and delete the other one):

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.